

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5702

CERTIFICATE OF DEATH

05691

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First FANNIE Middle B. Last BAILEY		4. DATE OF DEATH Month May Day 13 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 11, 1873
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel K. Fretz		14. MOTHER'S MAIDEN NAME Mary E. Bayer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Mary Bramble,		Address Millington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X cerebral Arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General Arterio-sclerosis DUE TO (c) Senility PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. None 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 19 57 19 57 to May 13 19 59 , that I last saw the deceased alive on May 13 19 59 , and that death occurred at 1130 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE H. H. Hamilton		M.D. Millington Md	
PHYSICIAN'S NAME (Type) H. H. HAMILTON		DATE SIGNED 5/13/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 16, 1959	
22c. NAME OF CEMETERY OR CREMATORY Millington Cemetery		22d. LOCATION (City, town, or county) (State) Millington, Kent Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward S. Hollows		ADDRESS Millington Md	
24a. REC'D BY REGISTRAR MAY 20 '59		24b. REGISTRAR'S SIGNATURE Charles S. Kline	

CERTIFICATE OF DEATH

1920

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1875		Baltimore, Md.	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Occupation	
Heart Disease		Myocardial Infarction		Coronary Atherosclerosis		Natural		Farmer	
Date of Death		Place of Death		Physician		Medical Examiner		Burial Place	
Jan 15, 1920		Home		Dr. J. Smith		None		Catholic Cemetery	
Signature of Physician		Signature of Medical Examiner		Signature of Registrar		Signature of Coroner		Signature of Burial Officer	
J. Smith		None		None		None		None	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5692

CERTIFICATE OF DEATH

Reg. Dist. No.

05692

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown c. LENGTH OF STAY IN 1b adult life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sarah Middle E. Last Cann		4. DATE OF DEATH Month May Day 12 , Year 1959	
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21, 1914
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months 4 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Kent Co. Md.	
11. BIRTHPLACE (State or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Cann		14. MOTHER'S MAIDEN NAME Katie Walker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-20-7679	
17. INFORMANT Levenia Maynor		18. ADDRESS (Street, city or town, state) Chestertown, Md.	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus 460X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombophlebitis of leg (c) Varicosis		INTERVAL BETWEEN ONSET AND DEATH 1-2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Marked obesity			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 12, 1959 , to May 12, 1959 , that I last saw the deceased alive on May 12, 1959 , and that death occurred at 11:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 203 N. Queens St DATE SIGNED HARRY PAUL ROSS			
ACTUAL SIGNATURE HARRY PAUL ROSS M.D.		PHYSICIAN'S NAME (Type) HARRY PAUL ROSS MD Chestertown, Maryland	
22a. BURIAL, CREMATION, REBURY (Specify) Burial		22b. DATE THEREOF May 16, 1959	
22c. NAME OF CEMETERY OR CREMATORY James Cem.		22d. LOCATION (City, town, or county) (State) near Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Waller ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE MAY 18 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1990

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5698

CERTIFICATE OF DEATH

Reg. Dist. No. 05698

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Queen Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>				c. LENGTH OF STAY IN 1b <u>17X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Kent and Queen Anne's Hospital</u>				d. STREET ADDRESS <u>Sudlersville</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Le Roy Hodge Coleman</u>				4. DATE OF DEATH Month Day Year <u>MAY 16 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 4, 1895</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>W. Rudolphus Coleman</u>				14. MOTHER'S MAIDEN NAME <u>ANNA Nickerson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Hosp. Records, Chestertown land</u>		17. INFORMANT <u>Hosp. Records, Chestertown land</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>7 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>5-13</u> , 19 <u>59</u> , to <u>5-16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5-16-59</u> , 19 <u>59</u> , and that death occurred at <u>11:30</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>5-16-59</u>							
ACTUAL SIGNATURE <u>A.C. Dick</u>				M.D. <u>5-16-59</u>			
PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>				<u>Chestertown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>MAY 20</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CRUMPTON</u>		22d. LOCATION (City, town, or county) (State) <u>CRUMPTON MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Rone</u>				ADDRESS <u>Church Hill</u>		24a. REC'D BY REGISTRAR <u>MAY 21 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>			

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CERTIFICATE OF DEATH

2000

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. TIME OF DEATH</p>		<p>10. PLACE OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. DATE OF DEATH</p>		<p>14. TIME OF DEATH</p>	
<p>15. PLACE OF DEATH</p>		<p>16. SIGNATURE OF WITNESS</p>	
<p>17. DATE OF DEATH</p>		<p>18. TIME OF DEATH</p>	
<p>19. PLACE OF DEATH</p>		<p>20. SIGNATURE OF WITNESS</p>	
<p>21. DATE OF DEATH</p>		<p>22. TIME OF DEATH</p>	
<p>23. PLACE OF DEATH</p>		<p>24. SIGNATURE OF WITNESS</p>	
<p>25. DATE OF DEATH</p>		<p>26. TIME OF DEATH</p>	
<p>27. PLACE OF DEATH</p>		<p>28. SIGNATURE OF WITNESS</p>	
<p>29. DATE OF DEATH</p>		<p>30. TIME OF DEATH</p>	
<p>31. PLACE OF DEATH</p>		<p>32. SIGNATURE OF WITNESS</p>	
<p>33. DATE OF DEATH</p>		<p>34. TIME OF DEATH</p>	
<p>35. PLACE OF DEATH</p>		<p>36. SIGNATURE OF WITNESS</p>	
<p>37. DATE OF DEATH</p>		<p>38. TIME OF DEATH</p>	
<p>39. PLACE OF DEATH</p>		<p>40. SIGNATURE OF WITNESS</p>	
<p>41. DATE OF DEATH</p>		<p>42. TIME OF DEATH</p>	
<p>43. PLACE OF DEATH</p>		<p>44. SIGNATURE OF WITNESS</p>	
<p>45. DATE OF DEATH</p>		<p>46. TIME OF DEATH</p>	
<p>47. PLACE OF DEATH</p>		<p>48. SIGNATURE OF WITNESS</p>	
<p>49. DATE OF DEATH</p>		<p>50. TIME OF DEATH</p>	
<p>51. PLACE OF DEATH</p>		<p>52. SIGNATURE OF WITNESS</p>	
<p>53. DATE OF DEATH</p>		<p>54. TIME OF DEATH</p>	
<p>55. PLACE OF DEATH</p>		<p>56. SIGNATURE OF WITNESS</p>	
<p>57. DATE OF DEATH</p>		<p>58. TIME OF DEATH</p>	
<p>59. PLACE OF DEATH</p>		<p>60. SIGNATURE OF WITNESS</p>	
<p>61. DATE OF DEATH</p>		<p>62. TIME OF DEATH</p>	
<p>63. PLACE OF DEATH</p>		<p>64. SIGNATURE OF WITNESS</p>	
<p>65. DATE OF DEATH</p>		<p>66. TIME OF DEATH</p>	
<p>67. PLACE OF DEATH</p>		<p>68. SIGNATURE OF WITNESS</p>	
<p>69. DATE OF DEATH</p>		<p>70. TIME OF DEATH</p>	
<p>71. PLACE OF DEATH</p>		<p>72. SIGNATURE OF WITNESS</p>	
<p>73. DATE OF DEATH</p>		<p>74. TIME OF DEATH</p>	
<p>75. PLACE OF DEATH</p>		<p>76. SIGNATURE OF WITNESS</p>	
<p>77. DATE OF DEATH</p>		<p>78. TIME OF DEATH</p>	
<p>79. PLACE OF DEATH</p>		<p>80. SIGNATURE OF WITNESS</p>	
<p>81. DATE OF DEATH</p>		<p>82. TIME OF DEATH</p>	
<p>83. PLACE OF DEATH</p>		<p>84. SIGNATURE OF WITNESS</p>	
<p>85. DATE OF DEATH</p>		<p>86. TIME OF DEATH</p>	
<p>87. PLACE OF DEATH</p>		<p>88. SIGNATURE OF WITNESS</p>	
<p>89. DATE OF DEATH</p>		<p>90. TIME OF DEATH</p>	
<p>91. PLACE OF DEATH</p>		<p>92. SIGNATURE OF WITNESS</p>	
<p>93. DATE OF DEATH</p>		<p>94. TIME OF DEATH</p>	
<p>95. PLACE OF DEATH</p>		<p>96. SIGNATURE OF WITNESS</p>	
<p>97. DATE OF DEATH</p>		<p>98. TIME OF DEATH</p>	
<p>99. PLACE OF DEATH</p>		<p>100. SIGNATURE OF WITNESS</p>	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G243 5/28/59 cap

CERTIFICATE OF DEATH

05694

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Still Pond		c. LENGTH OF STAY IN TB adult life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle Davis Last Davis		4. DATE OF DEATH Month May Day 20 Year 1959	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 12, 1865
9. AGE (In years last birthday) 94 yrs.		10. IF UNDER 1 YEAR Months 1 Days 19	11. IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Various	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Don't Know		14. MOTHER'S MAIDEN NAME Don't Know	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Don't Know		16. SOCIAL SECURITY NO. no	
17. INFORMANT Kent Co. Welfare Board		Address Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Artificial Thrombosis 454X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Old age. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 15, 1959 , to May 20, 1959 , that I last saw the deceased alive on May 20th, 1959 , and that death occurred at 4 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE L. P. Atwell		DATE SIGNED 5/21/59	
PHYSICIAN'S NAME (Type) L. P. Atwell		ADDRESS (Street, city or town, state) Still Pond, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/23/59	22c. NAME OF CEMETERY OR CREMATORY Still Pond Cem.	22d. LOCATION (City, town, or county) (State) Still Pond, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Samuel W. Waller		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR MAY 25 '59		24b. REGISTRAR'S SIGNATURE Charles E. Friend	

100000

WESTLAND STATE DEPARTMENT OF HEALTH - BIRMINGHAM, ALA.

CERTIFICATE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

WESTLAND STATE DEPARTMENT OF HEALTH - BIRMINGHAM, ALA.

1501410 1300410

1501410 1300410

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

5704

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Galena		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Galena	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FANNIE Middle A. Last DIXON		4. DATE OF DEATH Month May Day 23 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April, 24, 1867
9. AGE (In years last birthday) yrs. 92		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Emory Camp		14. MOTHER'S MAIDEN NAME Susan A. Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Pearle Fogwell,		Address Galena, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1 , 19 59 , to May 23 , 19 59 , that I last saw the deceased alive on May 23 , 19 59 , and that death occurred at 9:45 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Wallace Orenshain M.D.		ADDRESS (Street, city or town, state) Cecilton, Md. DATE SIGNED 25 May 59	
PHYSICIAN'S NAME (Type) WALLACE ORENSHAIN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May, 27, 1959	22c. NAME OF CEMETERY OR CREMATORY Galena Cemetery	22d. LOCATION (City, town, or county) (State) Galena, Kent Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Edward Sellers		24a. REC'D BY REGISTRAR DATE MAY 28 '59	
ADDRESS Wellington, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

5705

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05696

Item 9 Film 6243 5/27/59 cap

Reg. Dist. No.

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rock Hall	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Piney Neck		e. STREET ADDRESS Piney Neck	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Elizabeth Gaines		4. DATE OF DEATH Month Day Year May 1 1959	
5. SEX F	6. COLOR OR RACE J	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10, 1911
9. AGE (In years) 47 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY cannery	
11. BIRTHPLACE (State or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Isaac Hanson		14. MOTHER'S MAIDEN NAME Mattie Black	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 212-30-3156	
17. INFORMANT William Hanson		Address Rock Hall, Md.	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 581.0 DUE TO (b) Anasarea Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last, (c) Probable Hepatitis and Cirrhosis of Liver 1 or 2 years		INTERVAL BETWEEN ONSET AND DEATH 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert W. Farr, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Robert W. Farr, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 5/18/59	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/18/59	
22c. NAME OF CEMETERY OR CREMATORY Sharptown Cemetery		22d. LOCATION (City, town, or county) (State) Rock Hall, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin J. Williams		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR DATE MAY 19 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



5706 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Main St. + Haven Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Emma I</u> Middle <u>Hanna</u> Last <u>Hanna</u>				4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1959</u>			
5 SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 19, 1876</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housekeeping</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11 BIRTHPLACE (State or foreign country) <u>Baltimore Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles W. Hanna</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Crawford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Mathie J. Davis</u> Address <u>Rock Hall Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>venousity</u> <u>174x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March, 1959</u> , to <u>May 13, 1959</u> , that I last saw the deceased alive on <u>May 13, 1959</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>E. J. Lester</u> M.D.				Rock Hall			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/16/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel Am.</u>		22d. LOCATION (City, town, or county) (State) <u>Rock Hall Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin V. Williams</u> ADDRESS <u>Chestertown Md</u>				24a. REC'D BY REGISTRAR <u>MAY 19 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05698

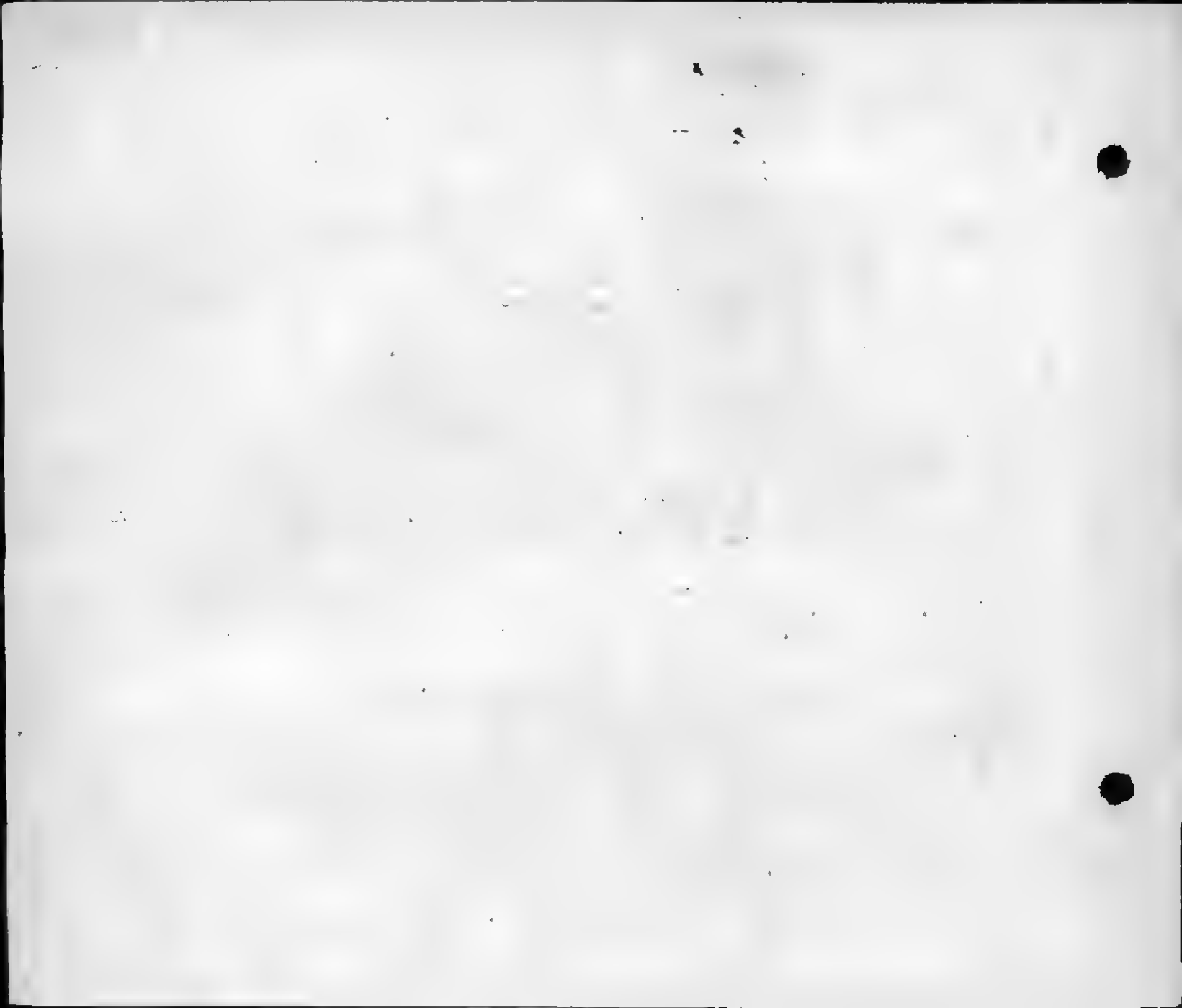
5699

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Philadelphia	
c. LENGTH OF STAY IN 1b less than 1 day		d. STREET ADDRESS 6911 Linmore Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Kent & Queen Anne Hosp.		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Russell G Smith		4. DATE OF DEATH Month May Day 30 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1917
9. AGE (in years last birthday) 41 yrs		10. IF UNDER 1 YEAR Months 1 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction		10b. KIND OF BUSINESS OR INDUSTRY Building	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Smith		14. MOTHER'S MAIDEN NAME Mary Lawrence	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW 2		16. SOCIAL SECURITY NO. WW 2	
17. INFORMANT Personal papers found in car of deceased		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unknown, but possibly due to a combination of natural and accidental causes. Frequently a patient in VA hospital. Carried drug resembling Dilantin. Had had an old operation on left side, upper frontal area of head. Was drinking, dove into water, was pulled out, vomited at 5 PM. Seen by MD who said he had no idea of cause of death. Advised hospital. Died en route at about 9:30 PM. Had been talking to deceased. DUE TO (b) an old operation on left side, upper frontal area of head. DUE TO (c) head. Was drinking, dove into water, was pulled out, vomited at 5 PM. Seen by MD who said he had no idea of cause of death. Advised hospital. Died en route at about 9:30 PM. Had been talking to deceased.			
INTERVAL BETWEEN ONSET AND DEATH PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. 5		20b. DESCRIBE HOW INJURY OCCURRED (Enter as follows: For 20c. TIME OF INJURY, Month, Day, Year; For 20d. INJURY OCCURRED, White at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> ; For 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) dove in water at Kennmore Park Md, May have had a seizure after entering water.	
20c. TIME OF INJURY Month, Day, Year 5 a. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Waterfront near Kennedyville, Kent, Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <i>Robert W. Farr</i>		DATE SIGNED May 31, 1959	
EXAMINER'S NAME (Type) Robert W. Farr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/3/59	
22c. NAME OF CEMETERY OR CREMATORY Beverly Nat. Cem.		22d. LOCATION (City, town, or county) (State) Beverly New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Willis Wells</i>		24a. REC'D BY REGISTRAR JUN 2 '59	
ADDRESS Chestertown, Md.		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PNG. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5707 CERTIFICATE OF DEATH

Reg. Dist. No.

05699

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD Edesville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Natasha Lynette Stewart		4. DATE OF DEATH Month May Day 29 Year 1959	
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 26, 1959
9. AGE (In years last birthday) 2 yrs.		10. IF UNDER 1 YEAR Months 2 Days 3	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Kent Co. Md.
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME Cleveland Stewart	
14. MOTHER'S MAIDEN NAME Mary Ann Thomas		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. no		17. INFORMANT Mary Ann Thomas Stewart Address Rock Hall, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Primate Incontinence DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) 1			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Rock Hall, Md.		(County) _____ (State) _____	
21. I certify that I attended the deceased from 5/29 , 19 59 , to 5/29 , 19 59 , that I last saw the deceased alive on Dec 3/29, 1959 , and that death occurred at 8:30 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Eugene Kester		ADDRESS (Street, city or town, state) Rock Hall, Md. DATE SIGNED 5/30/59	
PRINTED NAME (Type) Eugene Kester		md	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 30, 1959	
22c. NAME OF CEMETERY OR CREMATORY Sharptown Cem.		22d. LOCATION (City, town, or county) Rock Hall, Md. (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Waller		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR JUN 1 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kinner	



5708 CERTIFICATE OF DEATH

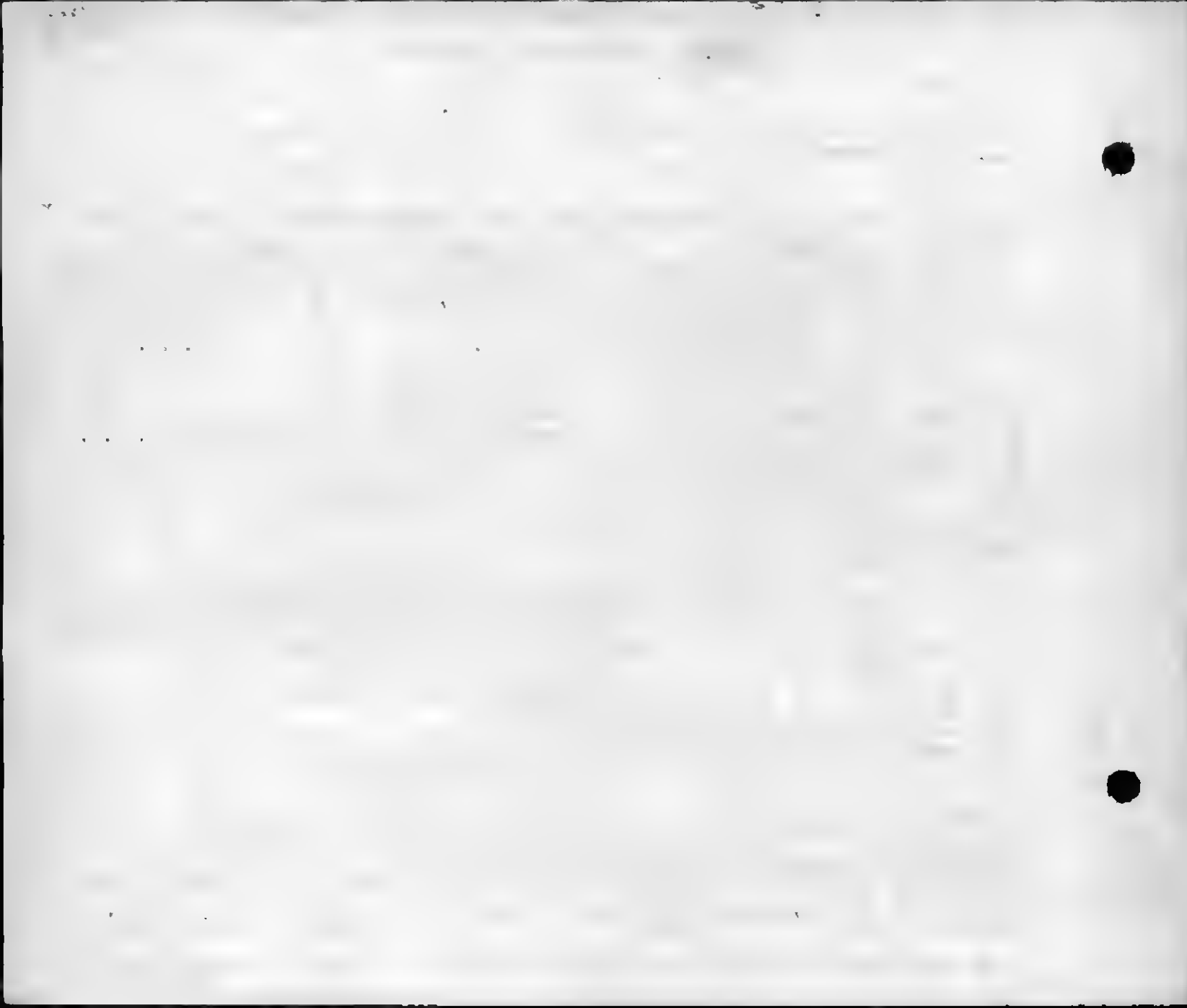
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Millington		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Millington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First LILLIE Middle THOMAS Last THOMAS		4. DATE OF DEATH Month May Day 15 Year 19 59	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12, 1888
9. AGE (In years last birthday) yrs. 70		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elliot Brown		14. MOTHER'S MAIDEN NAME Lillie Ford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Waman Thomas,		Address Millington, Md. R.D.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident (stroke). DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c) Cerebral hemorrhage hemiplegia			INTERVAL BETWEEN ONSET AND DEATH 3 days 15-20 years 14 1/2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 22, 1954 , to May 15, 1959 , that I last saw the deceased alive on May 12, 1959 , and that death occurred at 12:00 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward Koralewski		ADDRESS (Street, city or town, state) MILLINGTON, MD	
PHYSICIAN'S NAME (Type) EDWARD KORALEWSKI		DATE SIGNED 5-16-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 18, 1959	22c. NAME OF CEMETERY OR CREMATORY Chesterville Cemetery	22d. LOCATION (City, town, or county) (State) Rural Millington, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows, Millington, Md.		24a. REC'D BY REGISTRAR DATE MAY 19 '59	24b. REGISTRAR'S SIGNATURE Orlino S. Kraus

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5700 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Worton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Kent & Annapolis Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elva Elizabeth Wessel</u>				4. DATE OF DEATH Month Day Year <u>May 18 1959</u>			
5 SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-17-12</u>	9. AGE (In years last birthday) <u>46</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Jackson</u>				14. MOTHER'S MAIDEN NAME <u>Alice Cranor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hosp. Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> <u>465 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>post-operative</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5-12</u> , 19 <u>59</u> , to <u>5-18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5-18</u> , 19 <u>59</u> , and that death occurred at <u>4:15</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>A.C. Tink</u> M.D.				PHYSICIAN'S NAME (Type) <u>A.C. Tink</u> <u>Chestertown, Md</u> <u>5-19-59</u>			
22a. BURIAL, CREMATION, OR DISPOSAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 21, 1959</u>		<u>Chesler Cem.</u>		<u>Chestertown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward F. Edwards</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05702

Reg. Dist. No.

5701

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY KENT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b less than 1 day X Worton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Annes				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Raymond Middle Alfred Last Wilson				4. DATE OF DEATH Month May Day 30 Year 19 59			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 3 1931	
9. AGE (in years last birthday) 28 yrs.		IF UNDER 1 YEAR Months 28 Days 28 Hours 28 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY USA							
13. FATHER'S NAME James E. Wilson				14. MOTHER'S MAIDEN NAME Hynson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes 1951-1953		16. SOCIAL SECURITY NO. 215-26-5795		17. INFORMANT Magnolia Wilson Worton, Md. (Wife)			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Natural (Probably coronary thrombosis) DUE TO (b) Deceased, previously perfectly well awakened Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) from his sleep and complained of severe pain in his chest and back, which radiated to his arm. He took bicarbonate PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) for presumed indigestion, and fell over unconscious after about 1/2 hour. Was dead on arrival at the hospital.				INTERVAL BETWEEN ONSET AND DEATH 1/2 hour			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Robert W. Farr				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) ROBERT W. FARR				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6/3/59		22c. NAME OF CEMETERY OR CREMATORY Butlertown Cem.	
22d. LOCATION (City, town, or county) (State) Worton, Md. Kent Co.							
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth W. Weller				ADDRESS Chestertown, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
				24a. REC'D BY REGISTRAR DATE JUN 2 '59			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

5709

CERTIFICATE OF DEATH

Reg. Dist. No. 05703

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Galena		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Galena	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last Mary F. Wise		4. DATE OF DEATH Month Day Year May 21 19 59	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 26, 1891
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur Caulk		14. MOTHER'S MAIDEN NAME Hester Vilo	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT James Wise,		Address Golts, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute heart failure 416x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) regeneration of the myocardium. DUE TO (c) phlebotomic heart disease			INTERVAL BETWEEN ONSET AND DEATH 6 days 2 years? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 24, 1957 to May 21, 1959 that I last saw the deceased alive on May 15, 1959 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Geza Koralewski		ADDRESS (Street, city or town, state) Millington, Md	
PHYSICIAN'S NAME (Type) GEZA KORALEWSKI		DATE SIGNED 5.22.59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/25/59	22c. NAME OF CEMETERY OR CREMATORY Olivet Hill Cem.	22d. LOCATION (City, town, or county) (State) Rural Galena Md
23. FUNERAL DIRECTOR'S SIGNATURE Edward J. Holloway		ADDRESS Millington Md.	
24a. REC'D BY REGISTRAR DATE MAY 27 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

105203

Date of Death 1914		Time of Death 10:00 AM	
Place of Death 100 West Street, Boston, Mass.		Name of Deceased John J. Smith	
Age of Deceased 45		Sex of Deceased Male	
Race of Deceased White		Marital Status Married	
Name of Spouse Mary J. Smith		Name of Physician Dr. J. H. Jones	
Name of Undertaker J. H. Jones		Name of Burial Place St. John's Cemetery, Boston, Mass.	
Cause of Death Heart Disease			
Manner of Death Natural			
Signature of Physician J. H. Jones			
Signature of Undertaker J. H. Jones			
Signature of Registrar J. H. Jones			